STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
	495409	A BUILOING _____ B WING _____	C 08/27/2015

NAME OF PROVIOER OR SUPPLIER	STREET AOORESS. CITY. STATE. ZIP COOE
ABINGDON HEALTH CARE LLC	15051 HARMONY HILLS LANE ABINGDON, VA 24212

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F 000	INITIAL COMMENTS	F 000		

An unannounced Medicare/Medicaid standard survey was conducted 8/25/15 through 8/27/15. Complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow.

The census in this 120 certified bed facility was 111 at the time of the survey. The survey sample consisted of 22 current Resident reviews (Residents 1 through 20 and Residents 27 and 28) and 6 closed record reviews (Residents 21 through 26).

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F 155 SS=D 483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES

F 155

The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section.

The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.

1. Advance Directives (DDNR/Golden Rod) for resident # 11 was reviewed and corrected to indicate the resident's capacity to make an informed decision about providing, withholding or withdrawing specific medical treatment or course of treatments and signed by the physician. Resident #11 Advance Directive (DDNR/Golden Rod) was corrected on September 1, 2015.
2. Any resident has the potential to be affected if the DDNR is not accurately completed. A 100% audit of residents with DNR orders will be completed to ensure DDNRs in place are accurately completed.

LABORATORY DIRECTOR'S OR PROVIOER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 9-25-15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

per SP

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F 155	Continued From page 1	F 155		

This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review the facility staff failed to accurately complete a DDNR (Durable Do Not Resuscitate) order form for 1 of 28 Residents, Resident #11.

The findings included.

The DDNR order form did not include a date and section's 1 and 2 had not been completed.

Resident #11 was admitted to the facility 08/15/14. Diagnoses included, but were not limited to, hypertension, dementia, depressive disorder, and diabetes.

Section C (cognitive status) of the Residents annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 06/24/15 scored the Resident 4 out of a possible 15 points. The Resident was not interviewable.

The Residents clinical record contained an "Order Summary Report" that included a DNR (Do Not Resuscitate) order. The order date was documented as 08/21/14.

The clinical record also included a copy of the Residents DDNR order form from the Virginia Department of Health. The area on this form for the date had been left blank.

Under section 1 the DDNR read in part, "I further certify [must check 1 or 2]:
1. The patient is CAPABLE of making an informed decision...

3. Licensed nursing staff, Social Services staff, Admissions staff and Medical staff (Physician/NP/PA) will be educated on the proper execution of DDNR forms indicating resident capacity to consent.
4. Social Services Director or designee will audit the DDNR forms for new admissions weekly for 4 weeks and then monthly for 2 months to ensure accurate completion. Evidence of non-compliance will be addressed and results will be reported to QA for further discussion and recommendations.
5. Completion date: October 8, 2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 155	Continued From page 2 2. The patient is INCAPABLE of making an informed decision..." The boxes beside #1 and #2 had been left blank. Section 2 read "If you checked 2 above, check A, B, or C below:" The three boxes below had also been left blank. The administrator, DON (director of nursing), ADON (assistant director of nursing), and nurse consultant were notified of the incomplete DDNR order form in a meeting with the survey team on 08/26/15 at approximately 11:30 a.m. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 155		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).	F 157	**Corrective Action** Duly noted. Resident #21 was a closed record review. Resident #21 did not receive any ill effects from facility staff failing to notify responsible party of fall sustained 3/26/15 without injury. **Other potential residents:** Any resident has the potential to be affected if RP's are not notified.	

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F 157	Continued From page 3	F 157		

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, the facility staff failed to notify the responsible party (RP) of a fall for 1 of 28 residents (Resident #21).

The findings include:

Resident #21 was admitted to the facility on 3/21/15, with diagnoses that included but not limited to: hypertension, depression, esophageal reflux disease, atrial fibrillation, heart failure, thyroid disorder, and insomnia.
A review of Resident #21's clinical record revealed on the most recent minimum data set (MDS) with an assessment reference date of 3/28/15, the facility staff assessed the resident to understand and to be understood. She requires assistance with all activities of daily living (ADL).

Continued review of the residents closed electronic clinical record revealed the following nurses note in part: " 3/26/15 23:06; Resident yelling out at this time. Upon on entering room

Systemic Changes:

All residents' records will be audited whenever a resident has a fall for RP notification.

Monitoring:

Unit Managers will monitor all resident orders for RP notification daily for 4 weeks and weekly for 4 weeks. Evidence of non-compliance will be addressed and results reported to QA committee. This plan will be effective on October 8, 2015.

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F 157	Continued From page 4 resident is found sitting in her floor beside of her bed. Assisted into w/c (wheel chair), no noted injury at this time. " Review of the residents electronic clinical record did not reveal notification of the RP. On 8/27/15 at 8:15am, the director of nurses was asked if she could locate documentation of notification of the RP related to the 3/26/15 fall. After researching the clinical record the director of nurses replied " I couldn ' t find the notification. " Prior to exit on 8/27/15 no further information was provided to the surveyor related to the failure to notify the RP.	F 157		
F 226 SS=B	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and employee record review, the facility failed to follow their policy and procedure for the screening of new employees for 5 of 5 new hires. The findings included. The facility was unable to provide the surveyor with reference checks for 5 of 5 new hires and did	F 226	F-226 Corrective Action 1. 5 of the 5 new hires identified during survey have had references checks initiated. New hire #3 had license verification completed during survey.	

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F 226	Continued From page 5	F 226		

not obtain licensure verification for an LPN (licensed practical nurse) until the time of the survey.

On 08/26/15 the surveyor reviewed 5 new hire employee records.

None of these 5 employee records included reference checks. When HR (human resource) employee #1 was asked about the reference checks she stated she had only been employed at the facility for a short while and was unable to find the reference checks.

New hire #3, who was an LPN, was hired at the facility on 06/23/15 the facility did not verify the employees license until the time of the survey (08/25/15). When asked about the license verification HR employee #1 verbalized to the surveyor that she had checked the employee records after they had been requested by the survey team leader and when she noticed the license verification was not in the employee file she verified the licensed.

The facility policy/procedure titled "Hiring Process, Evaluation, Employee Records, Resignations and Terminations" read in part. "References-Check all references before extending a job offer. (Two (2) references required.)...License Verification...Verify the license online through the Virginia Department of Health Professions...before the hire date..."

The administrator, DON (director of nursing), ADON (assistant director of nursing), and nurse consultant were notified of the above in a meeting with the survey team on 08/26/15 at approximately 11:30 a.m.

2. Any resident has the potential to be affected if screening of new hires is not completed. Current employee records will be audited to ensure reference checks obtained to extent former employer provides and license verifications on file.

3. The new hired Human Resources Generalist has received education on the Hiring Process, Evaluation, Employee Records, Resignations and Terminations policy and regulatory requirements.

4. HR Generalist or designee will audit employee records of new hires weekly for 3 months and submit to the facility Administrator, Safety Committee and QA Committee for review and oversight.

5. 5. Completion date: October 8, 2015

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F 226	Continued From page 6 No further information regarding this issue was provided to the survey team prior to the exit conference.	F 226		
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by:	F 278	**Corrective Action:** Resident #4 has since had an MDS assessment 8/18/15, which reflected current pain status in Section J (Health Conditions) and Resident #4's clinical record was updated to reflect the current height. Resident #10's clinical record has been updated with a current BIMS to reflect resident's current cognitive status. Resident #1's MDS was modified and resubmitted to CMS on 8/25/15 to include dialysis while a resident on Section O. Resident #7 has been interviewed to reflect current pain status. Resident #23's MDS was modified and resubmitted to CMS on 8/26/15 to include hospice while a resident on Section O. Resident #13's clinical record was updated to reflect the current height.	

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F 278	Continued From page 7	F 278		

Based on staff interview, and clinical record review, the facility staff failed to ensure an accurate Minimum Data Set (MDS) assessment for 6 of 28 residents (Resident #4, #10, #1, #7, #23, and #13).

The findings include:

1. The facility staff failed to ensure an accurate MDS assessment for Resident #4.

Resident #4 was admitted to the facility on 7/29/13 with diagnoses of arthritis, seizure disorder, anxiety, insomnia, depression, diabetes, stroke, bipolar disorder, and hypertension. The current annual MDS with a reference date of 5/21/15 assessed the resident with a cognitive score of "15"of "15". The resident was assessed requiring extensive assistance of 1 person for bed mobility, transfers, dressing, toileting, bathing, and hygiene.

Section "J" for Health Conditions was reviewed. Section J0200 noted the pain assessment should be conducted. The resident and staff interviews related to pain were not completed and each question was marked with a dash (-).

Section "K" for Swallowing/Nutritional Status was reviewed for the MDS completed on 10/8/14 and 1/2/15. The 10/8/14 MDS noted the resident to be 67 inches tall. The following MDS assessment noted the resident to be 55 inches tall.

The MDS coordinator (RN#2 was interviewed on 8/26/15 at 10:20 a.m. and the MDS inaccuracies. RN#2 stated the resident must not have been available for the pain assessment.

Other potential residents:

Any resident has the potential to be affected if MDS sections C, J, K and O are inaccurately coded

Systemic changes:

MDS nurses have received education from the state CMS RAI training manual on how to correctly evaluate and code Sections J, K and O of the MDS. MDS nurses and Dietary Managers have received education from the state CMS RAI training manual on how to correctly evaluate and code Section K of the MDS. MDS nurses and Social Services have received education from the state CMS RAI training manual on how to correctly evaluate and code Section C of the MDS. Clinical staff to be educated on the facility's policy and procedure for obtaining heights

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The administrator, director of nursing, assistant director of nursing, and corporate nurse were informed of the findings during a meeting with the survey team on 8/26/15 at 4:00 p.m.

2. The facility staff failed to ensure a completed MDS assessment related to cognition for Resident #10.

Resident #10 was admitted to the facility on 3/25/15 with diagnoses of dementia, insomnia, hypertension, bipolar disorder, hip fracture, and atrial fibrillation.

The admission MDS with a reference date of 4/1/15 did not contain a completed Section "C" for Cognitive Patterns. All areas contained a dash (-).

The MDS coordinator (RN#2 was interviewed on 8/25/15 at 4:00 p.m. and the MDS inaccuracies. RN#2 stated the resident must not have been available for the cognitive assessment.

The administrator, director of nursing, assistant director of nursing, and corporate nurse were informed of the findings during a meeting with the survey team on 8/26/15 at 4:00 p.m.

3. For Resident #1, the facility staff failed to code the Residents dialysis status. The Resident was currently receiving hemodialysis three times a week.

Resident #1 was admitted to the facility 02/18/13. Diagnoses included, but were not limited to, end stage renal disease, bipolar disorder, depression, psychosis, anxiety, and hypertension.

Section C (cognitive patterns) of the Residents

Monitoring:

MDS nurses or designee will audit Section J for 12 residents weekly for 4 weeks, then monthly for 2 months. Social Services or designee will monitor MDS Section C for 12 residents weekly for 4 weeks, then monthly for 2 months. MDS nurses or designee will monitor MDS Section O for all residents receiving dialysis weekly for 4 weeks, then monthly for 2 months. Unit managers or designee will monitor new admission records for presence and accuracy of heights weekly for 4 weeks, then monthly for 2 months. Evidence of non-compliance will be addressed and results will be reported to QA for further discussion and recommendations.

This plan will be effective on October 8, 2015.

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significant change MDS (minimum data set) assessment was scored 9 out of a possible 15 points. Section O (special treatments, procedures, and programs) was NOT coded to indicate the Resident was receiving dialysis.

The Residents "Order Summary Report" included an order for HD (hemodialysis) on Monday, Wednesday, and Fridays.

On 08/25/15 at approximately 2:25 p.m. RN (registered nurse) #1, who was the MDS nurse, was asked about the coding on the MDS assessment.

On 08/25/15 at approximately 2:55 p.m. RN #1 verbalized to the surveyor that she had completed a correction today as the Residents dialysis had not been coded on the MDS.

The administrator, DON (director of nursing), ADON (assistant director of nursing), and nurse consultant were notified of the above in a meeting with the survey team on 08/26/15 at approximately 11:30 a.m.

No further information regarding this issue was provided to the survey team prior to the exit conference.

4. For Resident #7, the facility staff failed to complete the pain assessment portion of the MDS (minimum data set).

Resident #7 was admitted to the facility on 08/24/12 and readmitted on 01/30/15. Diagnoses included but not limited to congestive heart failure, hypertension, hyperlipidemia, cerebrovascular accident, hemiplegia, anxiety, depression, chronic obstructive pulmonary

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disease, chronic kidney disease, atrial fibrillation, gastroesophageal reflux disease, and coronary artery disease.

The most recent quarterly MDS with an ARD (assessment reference date) of 08/06/15 coded the Resident as a 12 of 15 in section C, Cognitive patterns. Section J, Health Conditions was coded as a "1" under pain management, which is the equivalent of "received scheduled pain medication". Subsection J0200, "Should Pain Assessment Interview be Conducted?" was coded 1 for yes. The pain assessment interview was incomplete.

Resident #7's CCP (comprehensive care plan) contained a problem which read in part "...has a potential for pain r/t neuropathy/history of headache and stiff joints..."

During a meeting with the administrative staff on 08/26/15 at approximately 1130, the missing assessment was brought to their attention.

The surveyor spoke with the MDS coordinator on 08/26/15 at approximately 1330 regarding the missing assessment. The MDS coordinator stated that the Resident had been out of the facility with family on the ARD date.

During a meeting with the administrative staff on 08/2/15 at approximately 1630, the concern of the missing pain assessment was discussed.
5. The facility staff failed to code when Resident #23 was admitted to hospice on 5/1/15.

The clinical record of Resident #23 was reviewed 8/26/15 and 8/27/15. Resident #23 was admitted to the facility initially 12/29/14 and readmitted

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5/1/15. Resident #23's diagnoses included but were not limited to debility, atrial fibrillation, chronic kidney disease, diabetes mellitus, acute pain, pressure ulcer, edema, hyperlipidemia, hypertension, esophageal reflux, and anxiety.

Resident #23's significant change in assessment minimum data set (MDS) assessment with an assessment reference date (ARD) of 5/14/15 coded the resident with a brief interview for mental status(BIMS) as 14 out of 15.

Resident #23 was admitted to the services of hospice on 5/1/15. The significant change MDS with ARD of 5/14/15 did not address this evidence. Section O Special Treatments, Procedures, and Programs Part K. Hospice Care column 2. was not marked to indicate that Resident #23 had hospice services.

The surveyor interviewed registered nurse #1 on 8/26/15 at 4:00 p.m. concerning the inaccurate MDS assessment. She acknowledged Resident #23 did have orders for hospice dated 5/1/15 and hospice should have been marked on the significant change MDS.

The surveyor informed the administrator, the director of nursing, the assistant director of nursing, and the corporate registered nurse of the above finding on 8/26/15 at 4:30 p.m.

No further information was provided prior to the exit conference on 8/27/15.

6.For Resident #13, the facility staff failed to code section k (height) on the resident's initial MDS assessment with an ARD (assessment reference date) of 5/13/15.

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	495409	A. BUILDING _____ B. WING _____	C 08/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABINGDON HEALTH CARE LLC	15051 HARMONY HILLS LANE ABINGDON, VA 24212

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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Resident #13 was originally admitted to the facility on 5/4/15. Her diagnosis included, but was not limited to: high blood pressure, diabetes, Parkinson ' s disease, bi-polar, anxiety, and osteoporosis.

The initial minimum data set assessment (MDS) with an assessment reference date (ARD) completed on 5/13/15 for Resident #13. The surveyor observed that Section k, had a dash mark in that section. In section K the dash mark was in the section for height.

The MDS nurse was interviewed on 8/26/15 at 2:55pm, and asked if section k for height should have been documented. She responded when the MDS was done the height was not in the nursing assessment. When asked if the height should have been documented on the initial MDS she said. " I agree it should have been on the assessment. "
Further review of the resident ' s clinical record revealed in the section for weight on 5/8/15, Resident #13 ' s weight was 160. The weight was documented in the clinical record prior to the ARD of 5/13/15.
On 8/26/15 the administration staff was informed of the undocumented height on Resident #13 ' s initial MDS.
Prior to exit on 8/27/15 at 10:00am no further information was provided to the surveyor related to the undocumented height.

F 281 SS=D — 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS — F 281

The services provided or arranged by the facility must meet professional standards of quality.

Corrective Action:

Physician order was obtained on August 26 for Resident #6's self-releasing seat belt with chair alarm.

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This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, and clinical record review, the facility staff failed to maintain professional standards of nursing practice for 1 of 28 residents (Resident #6).

The findings include:

The facility staff failed to obtain a physician order for a self releasing seat belt with a chair alarm for Resident #6.

The clinical record of Resident #6 was reviewed 8/25/15 and 8/26/15. Resident #6 was admitted to the facility 3/3/15 with diagnoses that included but not limited to dwarfism, paraplegia, stage 4 pressure ulcer sacrum, chronic obstructive pulmonary disease, neuromuscular bladder dysfunction, chronic pulmonary embolus, chronic pain, hypertension, long term use of anticoagulants, and hypokalemia.

Resident #6's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 8/3/15 assessed the resident with a cognitive summary score of 15 out of 15.

The surveyor interviewed Resident #6 on 8/25/15 at 2:25 p.m. Resident #6 was sitting in a wheelchair in the resident's room watching television. The surveyor observed a clip alarm attached to the wheelchair. Resident #23 informed the surveyor he had a seat belt around his waist that he could easily remove. He stated he liked the seat belt because he had had multiple falls from his wheelchair in the past.

Other potential residents:

Any resident has the potential to be affected if physician orders are not obtained for self-releasing seat belts and personal alarms. A 100% audit of residents with self-releasing seat belts and safety alarms will be conducted to ensure a physician order is in place for use of the safety device.

Systemic changes:

Licensed nurses will be educated on the nursing standard of practice and facility policy to obtain physician orders for safety devices.

Monitoring:

Unit Managers, Nursing Supervisors or designee will monitor the 24 hour report for any new safety device ordered daily (M-F) for 4 weeks and weekly for 8 weeks, and ensure the physician order is in place in the clinical record. Evidence of non-compliance will be addressed and results will be reported to QA for further discussion and recommendations.

Completion date: October 8, 2015.

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The surveyor reviewed Resident #6's August 2015 electronic physician orders. The surveyor found no physician orders for the use of the self releasing seatbelt.

The surveyor discussed the use of a seatbelt with the director of nursing and the corporate registered nurse on 8/26/15 at 4:15 p.m. Both stated a physician order was needed for the use of a seat belt. Both stated they would expect the nurse to write orders for the seat belt.

The surveyor informed the administrator, the director of nursing, the assistant director of nursing, and the corporate registered nurse of the above finding on 8/26/15 at 4:30 p.m. and requested the facility's standard of nursing practice for obtaining and writing physician orders.

The director of nursing provided the surveyor with the facility standard of practice for orders on 8/27/15 at 8:45 a.m. The policy read "Orders Federal and State Regulations 2. Telephone (verbal) orders may only be given to a licensed nurse or licensed ST, OT, or PT at the facility. Orders may be received from a physician, dentist, podiatrist, nurse practitioner or physician assistant, licensed to prescribe in Virginia."

No further information was provided prior to the exit conference on 8/27/15.

F 312 SS=D 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS

A resident who is unable to carry out activities of daily living receives the necessary services to

F 312

Corrective Action:

Resident #9 provided nail care by unit manager on 8/26/15.

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maintain good nutrition, grooming, and personal and oral hygiene.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and clinical record review, the facility staff failed to provide nail care for 1 of 28 residents (Resident #9).

The findings include:

The facility staff failed to provide nail care for Resident #9.

Resident #9 was admitted to the facility on 6/30/13 and readmitted on 6/7/15 with diagnoses of dementia. diabetes, hypertension, stroke, hip fracture, atrial fibrillation, anxiety, and anemia. The quarterly Minimum Data Set (MDS) with a reference date of 7/4/15 assessed the resident with a cognitive score of "4" of "15". The resident was assessed requiring extensive assistance of 1-2 persons for bathing, hygiene, eating, toileting, bed mobility, and transfers.

The resident was observed on 8/26/15 at 7:45 a.m. sitting in the dining area. The resident was fully dressed and unshaven. The resident's nails were observed to be long and unclean with jagged edges and dark debris under the nails on both hands.

The resident was observed in bed on 8/26/15 at 3:30 p.m. The unit manager(RN#3) accompanied the surveyor and asked the resident to show his hands. The resident was clean shaven and hair was damp at this time. The resident showed his

Other potential residents:

Any resident has the potential to be affected if nail care is not provided. A 100% audit will be conducted to identify residents who are need of nail care.

Systemic changes:

Nursing staff will be educated regarding policy and procedure relating to nail care.

Monitoring:

Unit managers or designee will perform random monitor of ten residents for nail care daily for 4 weeks, weekly for 4 weeks, and then monthly for 1 month. Evidence of non-compliance will be addressed and results reported to QA committee.

This plan will be effective on October 8, 2015.

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F 312	Continued From page 16 hands and again the nails were observed long and unkempt with debris under the nails. RN#3 stated his nails needed attention. The corporate nurse was asked and provided evidence of bathing for Resident #9. The report provided noted the resident had received a shower at 2:59 p.m. on 8/26/15. The administrator, director of nursing, assistant director of nursing, and corporate nurse were informed of the findings during a meeting with the survey team on 8/26/15 at 4:00 p.m.	F 312		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to obtain physician ordered pulse oximetry every shift for 1 of 28 residents (Resident #22). The findings include:	F 328	**Corrective Action:** Resident # 22 duly noted. Resident # 22 was a closed record review. **Other potential residents:** Any resident has the potential to be affected if pulse oximetry is not obtained and documented as ordered. A 100% audit of residents with pulse oximetry monitoring will be completed to ensure compliance with physician order. Licensed nurses will be educated on the standard of care and procedure for following physician orders for pulse oximetry monitoring and documentation	

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The facility staff failed to obtain physician ordered pulse oximetries for Resident #22.

The clinical record of Resident #22 was reviewed 8/26/15 and 8/27/15. Resident #22 was admitted to the facility 1/26/15 with diagnoses that included but not limited to fall with fractured pubic ramus, osteoarthrosis, muscle weakness, constipation, insomnia, edema, anxiety, depressive disorder, congestive heart failure, pneumonia, esophageal reflux, hypopotassemia, and hypertension.

Resident #22's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/2/15 assessed the resident with a cognitive summary score of 14 out of 15. Resident #22 was assessed to need extensive assistance of two persons for bed mobility, transfers, dressing, toilet use, and personal hygiene. Resident #22 required limited assistance of 1 person for eating and bathing. Resident #22's range of motion revealed no impairment in either upper extremity; however, the lower extremity had been assessed with impairment on one side. Bowel and bladder continence revealed Resident #22 was frequently incontinent of both.

The comprehensive care plan initiated and created on 2/20/15 for the focus area that read "Resident #22 has Congestive Heart Failure and HTN (hypertension), which impacts functional ability, comfort and overall quality of life." Interventions/Tasks read "Oxygen therapy per MD orders. Vital signs per MD orders. Observe for and report to MD as indicated s/sx (signs and symptoms) of Congestive Heart Failure: dependent edema of legs and feet, periorbital edema, SOB (shortness of breath) upon exertion,

Monitoring:

Unit Managers, Nursing Supervisors or designee will review the TARs for residents with physician ordered pulse oximetry monitoring daily (M-F) for 4 weeks and weekly for 8 weeks to ensure compliance. Evidence of non-compliance will be addressed and results will be reported to QA for further discussion and recommendations

This plan will be effective on October 8, 2015.

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cool skin, dry cough, distended neck veins, weakness, weight gain unrelated to intake, crackles and wheezes upon auscultation of the lungs, orthopnea, weakness and/or fatigue, increased heart rate, lethargy and disorientation."

The March 2015 physician order sheet (POS) was reviewed. The physician order read "Check pulse oximetry q (every) shift and prn (whenever necessary)."

The surveyor reviewed Resident #22's March 2015 electronic treatment administration record (eTAR). The March 2015 eTAR revealed shifts when there was no evidence the pulse oximetries had been obtained: Day shift--3/3/15, 3/4/15, 3/5/15, 3/14/15, 3/20/15, 3/22/15, and 3/29/15. One omission was evident on 3/28/15 on the evening shift. The progress notes from 3/1/15 through 3/31/15 were reviewed. The progress notes did not reveal evidence the pulse oximetries had been obtained as ordered on the dates listed in the note.

The surveyor reviewed the weights and vitals summary for March 2015. The electronic weights and vitals summary had no evidence the pulse oximetries had been obtained as ordered.

The surveyor informed the corporate registered nurse of the above dates/shifts when the pulse oximetry had not been obtained on 8/26/15 at 3:00 p.m. The corporate R.N. stated some nurses did work 12 hour shifts and she would check to see if this was the case.

The surveyor informed the administrator, the director of nursing, the corporate registered nurse, and the regional MDS nurse of the failure

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F 328	Continued From page 19 of the facility to obtain physician ordered pulse oximetries on 8/27/15 at 9:15 a.m. No further information was provided prior to the exit conference on 8/27/15.	F 328		
F 369 SS=D	483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to ensure physician ordered adaptive equipment was available for use during a breakfast meal for 1 of 28 Residents, Resident #12. The findings included: The facility failed to provide the Resident with their physician ordered "Small maroon spoon." Resident #12 was admitted to the facility 02/25/13. Diagnoses included but were not limited to, dysphagia, dementia, congestive heart failure, psychosis, and hypertension. Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 05/27/15 was coded 1/1/3 to indicate the Resident had problems with long and short term memory and was severely impaired in cognitive skills for daily decision making. Section G0110.H. (eating) was coded 3/2 to indicate the Resident required extensive assistance of one person. The Residents clinical record included an "Order Summary Report" that had been signed by the FNP (family nurse practitioner) 08/04/15. This	F 369	**Corrective Action:** Resident #12 duly noted Resident #12's maroon spoon order was reviewed and revised. **Other potential residents:** Any resident has the potential to be affected if physician orders are not followed for feeding equipment. .A 100% audit of the electronic medical record of current residents with therapeutic eating utensils ordered will be completed to ensure accuracy; corresponding meal cards will be audited to ensure type of adaptive equipment is identified.	

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F 369	Continued From page 20 order summary report included an order for a "small maroon spoon with all meals." On 08/26/15 at approximately 8:10 a.m. the surveyor observed C.N.A. (certified nursing assistant) #1 assisting Resident #12 with their breakfast meal. The surveyor observed C.N.A. #1 using a regular sized silver spoon to feed the Resident. The surveyor was able to observe the Residents meal ticket lying on the dining table. This meal ticket included documentation to indicate the Resident was to use a "small maroon spoon" at meals. The surveyor asked C.N.A. #1 about the missing small maroon spoon. C.N.A. #1 verbalized to the surveyor that "They don't always give it to us." C.N.A. #1 continued to feed the Resident using the large silver spoon. On 08/26/15 at approximately 9:30 a.m. the surveyor interviewed the DM (dietary manager). The DM was asked about the Residents small maroon spoon. The DM was able to show the surveyor the type of spoon the Resident used and stated that the spoon would have been wrapped, placed on the cart, and sent out to the unit with the meals. The administrator, DON (director of nursing), ADON (assistant director of nursing), and nurse consultant were notified of the above in a meeting with the survey team on 08/26/15 at approximately 11:30 a.m. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 369	**Systemic changes:** Nursing staff will be educated on the process for order entry of adaptive equipment and meal card recognition for adaptive feeding equipment. Dietary staff will be educated on the process for identifying residents with physician ordered adaptive feeding equipment and ensuring the equipment is available for use. **Monitoring:** Unit Managers and Dietary Manager or designees will make random meal observations at alternating meal times daily for 4 weeks, weekly for 4 weeks and monthly for 1 month to ensure therapeutic feeding equipment is available and being used as ordered. Evidence of non-compliance will be addressed and results will be reported	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of	F 431	**Corrective Action:** LPN #1 was provided education on the Medication Storage policy.	

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F 431	Continued From page 21 a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, the facility failed to ensure a medication cart was locked when not attended for one of three units in the facility, Highland Lane	F 431	Any resident has the potential to be affected if the medication cart is not locked and attended during medication pass and pour. **Systemic Changes:** Licensed nurses will be educated on the Medication Storage policy that includes locking the medication cart and not leaving it unattended during medication pass and pour. **Monitoring:** Unit Managers, Nursing Supervisors or designee will observe medication pass and pour of nurses on alternating shifts daily (M-F) for 4 weeks, weekly for 4 weeks and monthly for 1 week. Evidence of non-compliance will be addressed and results will be reported to QA for further discussion and recommendations. Completion date: October 8, 2015	

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F 431	Continued From page 22 (dementia unit).	F 431		

The findings included:

The medication cart was left unlocked when unattended by the nurse during a medication pass and pour observation on the dementia unit.

On 08/26/15 at approximately 0800, the surveyor observed LPN #1 during a medication pass and pour. LPN #1 prepared the medications, and then went to the Resident's room to administer them. LPN #1 failed to lock the medication cart when leaving it unattended to enter Resident rooms.

At approximately 0815, the surveyor asked LPN #1 if he could see the medication cart from the Resident rooms while he was administering medication and he stated that he could not. Surveyor then asked LPN #1 if he should lock the medication cart when he could not see it and he stated that he should. Surveyor then asked LPN #1 if he had locked the cart and he stated that he had not.

During a meeting with the administrative staff on 08/26/15 at approximately 1130, the concern of the medication cart being left unlocked was brought to their attention.

The DON (director of nursing) provided the surveyor with a copy of the policy "General Guidelines for Medication Storage" on 08/27/15. This policy read in part "Medication rooms, cart, and medication supplies are locked or attended by persons with authorized access".

The concern of the unlocked medication cart was discussed with the administrative staff on

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F 431	Continued From page 23 08/27/15 at approximately 0915.	F 431		
	No further information was provided prior to exit.			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it -
(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and

Corrective Action:

LPN #5 was educated on the infection control policy and procedure for hand washing during medication pass and pour. LPN#5 was provided an alternative hypoallergenic antibacterial agent for use.

Other potential residents:

Any resident has the potential to be affected if infection control policy and procedure is not adhered to concerning correct hand-washing techniques during medication passes.

Systemic changes:

Licensed nurses will be educated on the infection control policy and procedure for hand-washing during medication pass and pour, and the need to report any sensitivities to facility products so an alternative can be provided and infection control practices maintained

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ABINGDON HEALTH CARE LLC	15051 HARMONY HILLS LANE ABINGDON, VA 24212

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, the facility staff failed to follow infection control policy and procedure for hand washing during a medication pass and pour observation.

The findings include:

A medication pass and pour observation was conducted on 8/26/15 at 8:15 a.m. with staff member LPN#5.

LPN#5 was observed to pour medications for a resident administer them. The medications included an injection and application of a patch to the chest area of the resident.

LPN#5 was then observed to return to the medication cart and proceeded to prepare and administer oral medications to another resident. LPN#5 administered the medications and returned to the medication cart. LPN#5 was asked at this time why she failed to wash her hands between resident contact.

LPN#5 stated she had found she had an allergy to the soap and antibacterial soap the facility had recently switched to use. LPN#5 stated she used an alcohol prep pad to wash hands between resident contact, but admitted she had not done so while observed.

The assistant director of nursing was asked for

Monitoring:

Unit Managers or designee will conduct random hand washing audits during medication pass and pour of nurses on alternative shifts daily (M-F) for 4 weeks, weekly for 4 weeks and monthly for 1 week. Evidence of non-compliance will be addressed and results will be reported to QA for further discussion and recommendations.

This plan will be effective on October 8, 2015.

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F 441	Continued From page 25 the facility policy on hand washing on 8/26/15 and provided a copy. The facility Hand Washing policy stated "times when hand washing is very important" included , "before and after resident contact". The administrator, director of nursing, assistant director of nursing, and corporate nurse were informed of the findings during a meeting with the survey team on 8/26/15 at 4:00 p.m.	F 441		
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to obtain a physician ordered laboratory test for 1 of 28 residents (Resident #6). The findings include: The facility staff failed to obtain a PT/INR for Resident #6 on 4/20/15. The clinical record of Resident #6 was reviewed 8/25/15 and 8/26/15. Resident #6 was admitted to the facility 3/3/15 with diagnoses that included but not limited to dwarfism, paraplegia, stage 4 pressure ulcer sacrum, chronic obstructive pulmonary disease, neuromuscular bladder dysfunction, chronic pulmonary embolus, chronic pain, hypertension, long term use of	F 502	**Corrective Action:** Resident #6 had no ill effects from PT/INR that was not obtained. Resident #6's attending physician was notified that the 4/20/15 PT/INR was not obtained as ordered. **Other potential residents:** Any resident has the potential to be affected if ordered labs are not obtained. **Systemic Changes:** Licensed nurses will be educated on the procedure for obtaining labs as ordered	

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F 502	Continued From page 26 anticoagulants, and hypokalemia. Resident #6's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 8/3/15 assessed the resident with a cognitive summary score of 15 out of 15. The clinical record contained a scanned physician order dated 4/20/15 that read "1) INR today. 2) v CBC, CMP. 3). ? (change) Promethazine 25 mg ½ tab (tablet) po (by mouth) q (every) 6 ° (hours) prn (whenever necessary) nausea." The surveyor reviewed the electronic clinical record on 8/25/15 and 8/26/15 and was unable to locate the laboratory results. The surveyor requested the assistance of licensed practical nurse #3 to locate the results of the PT/INR ordered to be done on 4/20/15. L.P.N. #3 reviewed the clinical record, called the contracting laboratory and stated there were no results for that laboratory test on that day 4/20/15. The surveyor informed the administrator, the director of nursing, the assistant director of nursing, and the corporate registered nurse of the above finding on 8/26/15 at 4:30 p.m. No further information was provided prior to the exit conference on 8/27/15.	F 502	**Monitoring:** Unit Managers, Nursing Supervisors or designee will audit the clinical record for residents with PT/INR orders daily (M-F) for 4 weeks, weekly for 4 weeks and monthly for 1 month to ensure the laboratory test is obtained as ordered. Evidence of non-compliance will be addressed and results will be reported to QA for further discussion and recommendations. Completion date October 8, 2015.	
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete;	F 514		

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accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review the facility staff failed to ensure a complete and accurate clinical record for 3 of 28 Residents, Resident #12, #17, and #23.

The findings included.

1. For Resident #12, the Resident received cyanocobalamin (B12) one time a month. The physician ordered the medication to be given every month on the 18th. However the eMAR (electronic medication administration record) had the administration dates marked for the beginning of the month for June, July, and August.

Resident #12 was admitted to the facility 02/25/13. Diagnoses included, but were not limited to, dementia, congestive heart failure, psychosis, hypertension, insomnia, and dysphagia.

Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 05/27/15 was coded 1/1/3 to indicate the Resident had problems with long and short term

Corrective Action:

Resident #12's Cyanocobalamin (B12) order was updated in the eMAR to accurately reflect the monthly administration. Resident #17 received no ill effects from failure to document use of skin prep and Heelzup device. Resident #23 was a closed record review. Hospice notes for services provided to Resident #23 during her stay were obtained and scanned into the closed record.

Other potential residents:

Any resident has the potential to be affected if the clinical record is not maintained completely and accurately. A 100% audit of clinical records for residents with B12 orders will be completed to ensure order entry accuracy and documentation of administration. A 100% audit of TARs for residents with skin prep and Heelzup device orders will be completed to ensure accuracy and complete documentation of administration. A 100% audit of clinical records for residents receiving Hospice services will be completed to ensure presence of admission agreement, physician order and hospice notes.

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memory and was severely impaired in cognitive skills for daily decision making.

The Residents clinical record included an "Order Summary Report" that had been signed by the FNP (family nurse practitioner) on 08/04/15. This order summary report included an order for cyanocobalamin 1000 mcg/ml solution IM (intramuscular). Inject 1 ml IM every month due on the 18th.

A review of the eMAR's for June, July, and August 2015 indicated that the medication had been administered on June 1, July 2, and August 2.

On 08/27/15 at approximately 8:30 a.m. the surveyor interviewed LPN (licensed practical nurse) #2 regarding the medication and documentation. LPN #2 verbalized to the surveyor that when the medication was due to be given it would populate on the computer screen and only the medication(s) due that day and/or time would show on the computer screen.

The administrator, DON (director of nursing), ADON (assistant director of nursing), and nurse consultant were notified of the issue with the cyanocobalamin in a meeting with the survey team on 08/26/15 at approximately 11:30 a.m.

No further information regarding this issue was provided to the survey team prior to the exit conference.

2. For Resident #17, the facility nursing staff failed to document on the eTAR (electronic treatment administration record) for the administration of skin prep and use of the heelzup device.

Systemic changes:

Licensed nurses will be educated on documentation requirements to maintain a complete and accurate medical record.
Licensed nurses will be educated on reviewing the electronic health record Dashboard daily at change of shift to ensure all required MAR and TAR documentation is complete.

Monitoring:

Unit managers, Supervisors, staff RN's, or designee will monitor resident MAR/TAR/ and hospice records daily for 4 weeks, weekly for 4 weeks, and then monthly for 1 month. Evidence of non-compliance will be addressed and results reported to QA committee.

This plan will be effective on October 8, 2015.

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Resident #17 was admitted to the facility 12/28/12. Diagnoses included, but were not limited to, dementia, epilepsy, hypertension, and anxiety.
Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 06/08/15 scored the Resident 3 out of a possible 15 points.
The Residents clinical record included an "Order Summary Report" that included orders to "Apply skin prep to bilateral heels, every day shift" and "Heelzup device to use while in bed or reclining chair as tolerated. every shift."
A review of the eTARs for August 2015 indicated that the facility nursing staff had not documented they had administered the skin prep on August 5, 6, 8, 20, and 24. They had also not documented for the heelzup device on August 5, 6, 8, 20, and 24 on day shift.
On 08/26/15 at approximately 3:50 p.m. the surveyor and LPN (licensed practical nurse) #3 attempted to visualize the Residents heels. The Residents heels were observed to be elevated up off the bed with the heelzup device. However, the Resident refused to allow the surveyor and LPN #3 to visualize her heels. LPN #3 stated the Resident did not have any breakdown to the heel areas.
The administrator, DON (director of nursing), ADON (assistant director of nursing), and nurse consultant were notified of the incomplete documentation regarding the skin prep and heelzup device in a meeting with the survey team on 08/26/15 at approximately 11:30 a.m.

No further information regarding this issue was provided to the survey team prior to the exit conference.

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3. The facility staff failed to ensure Resident #23's electronic medical record was complete and accurate. The electronic medical record did not reveal any hospice documentation related to admission agreement, physician orders, and hospice notes.

The clinical record of Resident #23 was reviewed 8/26/15 and 8/27/15. Resident #23 was admitted to the facility initially 12/29/14 and readmitted 5/1/15. Resident #23's diagnoses included but were not limited to debility, atrial fibrillation, chronic kidney disease, diabetes mellitus, acute pain, pressure ulcer, edema, hyperlipidemia, hypertension, esophageal reflux, and anxiety. Resident #23's significant change in assessment minimum data set (MDS) assessment with an assessment reference date (ARD) of 5/14/15 coded the resident with a brief interview for mental status (BIMS) as 14 out of 15.

Resident #23 was admitted to hospice on 5/1/15. The surveyor interviewed the corporate registered nurse on 8/26/15 at 4:00 p.m. and was informed that hospice notes should be under the "Miscellaneous" tab on the computer. The electronic medical record revealed three documented pages that Resident #23 had hospice: orders dated 5/1/15 for hospice admission, a two page scanned med list dated 5/27/15 and a form titled "Witness of Removal of Human Remains" dated 6/18/15. The electronic medical record contained no admission contract, admission physician orders, or hospice notes.

Medical records other #7 was interviewed on 8/27/15 at 8:00 a.m. if she had hospice information that had not been scanned into the computer for Resident #23. She stated she didn't

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do the skilled unit. Medical records other #7 and the surveyor looked for paper documentation from the hospice agency for Resident #23 on the skilled unit and found no "notebook" for Resident #23's hospice notes/orders. She stated she would check with the unit secretary for the skilled unit when she arrived for work.

The surveyor asked the medical records other #7 if the hospice notes had been found and she informed the surveyor that the hospice notes were being faxed to the facility now.

The surveyor informed the administrator, the director of nursing, the regional minimum data set nurse, and the corporate registered nurse of the above finding on 8/27/15 at 9:15 a.m.

During the meeting, the surveyor asked the director of nursing if she would expect the notes to be available now rather than two months after Resident #23 had expired in the facility and she nodded "yes." Resident #23 expired 6/18/15 in the facility.

No further information was provided prior to the exit conference on 8/27/15.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNF/NF/SNF/NFs	PROVIDER # 495409	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING	DATE SURVEY COMPLETE 8/27/2015

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F 164	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS

The resident has the right to personal privacy and confidentiality of his or her personal and clinical records

Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.

Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.

The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.

The facility must keep confidential all information contained in the residents records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and facility document review, the facility staff failed to protect private healthcare information for 2 of 28 Residents, Resident #27 and #28.

The findings included:

1. For Resident #27, the facility staff failed to close/cover the computer screen containing the Residents private healthcare information during a medication pass and pour observation

Resident #27 was admitted to the facility on 01/21/15. Diagnoses included but not limited to dementia, anxiety and dysphagia.

The most recent MDS (minimum data set) with and ARD (assessment reference date) of 08/15/15 coded the Resident as 0 of 15 in section C. cognitive patterns.

On 08/26/15 at approximately 0810, during a medication pass and pour observation, the surveyor observed LPN #1 walking away from the medication cart leaving the computer screen open and uncovered. The computer screen contained private healthcare information for Resident#27.

On 08/26/15 at approximately 0825, the surveyor asked LPN #1 if he had closed/covered the computer screen when he walked away, and he stated that he had not. Surveyor asked him if he should have closed/covered the screen and he stated that he should have.

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On 08/26/15 at approximately 1130 during a meeting with the administrative staff, the incident was brought to their attention.

On 08/27/15 at 0830, the DON (director of nursing) provided the surveyor with a copy of the facility policy on "Privacy and Confidentiality". The policy read in part "...recognizes the following is protected health information per the Privacy Rule: Individually identifiable health information including demographic information..." and "Limit computer access to PHI (prutected health information) by using password protection and automatic screensavers that require password entry to reopen screen".

During a final meeting with the administrative staff on 08/27/15 at approximately 0915, the incident was discussed. No further information was provided prior to exit

2. For Resident #28, the facility staff failed to close/cover the computer screen containing the Residents private healthcare information during a medication pass and pour observation

Resident #28 was admitted to the facility on 12/02/13 and readmitted on 02/28/15. Diagnoses included but not limited to hypertension, hyperlipidemia, cardiovascular accident, dementia anxiety, depression, psychotic disorder, chronic obstructive pulmonary disease, and gastroesophageal reflux disease.

The most recent quarterly MDS (minimum data set) with and ARD (assessment reference date) of 06/24/15 coded the Resident as 7 of 15 in section C, cognitive patterns.

On 08/26/15 at approximately 0800, during a medication pass and pour observation the surveyor observed LPN #1 walking away from the medication cart leaving the computer screen open and uncovered. The computer screen contained private healthcare information for Resident#28.

On 08/26/15 at approximately 0825, the surveyor asked LPN #1 if he had closed/covered the computer screen when he walked away, and he stated that he had not. Surveyor asked him if he should have closed/covered the screen and he stated that he should have.

On 08/26/15 at approximately 1130 during a meeting with the administrative staff, the incident was brought to their attention.

On 08/27/15 at 0830, the DON (director of nursing) provided the surveyor with a copy of the facility policy on "Privacy and Confidentiality". The policy read in part "...recognizes the following is protected health information per the Privacy Rule: Individually identifiable health information including demographic information..." and "Limit computer access to PHI (protected health information) by using password protection and automatic screensavers that require password entry to reopen screen".

During a final meeting with the administrative staff on 08/27/15 at approximately 0915, the incident was discussed. No further information was provided prior to exit

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Corrective Action:

LPN#1 was provided education on the Privacy and Confidentiality policy

Other potential residents:

All residents have the potential to be affected if computer screens are not closed or covered during medication pass and pour.

Systemic Changes:

Licensed nurses will be educated on the Privacy and Confidentiality policy that includes closing or covering the eMAR screen during medication pass and pour.

Monitoring:

Unit Managers, Supervisors, Staff RN's will monitor 2 medication passes per week times 4 weeks, then 1 per week for 2 weeks, then monthly for 1 months. Evidence of non-compliance will be addressed and results reported to QA committee.

This plan will be effective on October 8, 2015.